# Annual Enrollment Form

## Virginia Child and Adult Care Food Program

ONE FORM PER ENROLLED CHILD, NEW FORM MUST BE COMPLETED EVERY 12 MONTHS

| This form is required for: | This form is NOT required for: |
|---|---|
| Child Care Centers, Head Start, Even Start, and Licensed Outside School Hours Programs | At-Risk After-School, or Emergency Shelters |

**Center Information –** ***Sponsoring Institutions should pre-fill this section***

CREATIVE WONDERS LEARNING CENTER — Center Name
59372 — CACFP Sponsor Number

2746 STUARTS DRAFT HWY. — Center Address
STUARTS DRAFT — City
VA — State
24477 — Zip Code

PARENTS/CENTERS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to complete or review a CACFP Annual Enrollment Form when enrolling their child(ren) and 12 months thereafter. This information will help ensure all children receive appropriate meals during their care. The parent or center may complete Sections 1 through 4. **The parent must review to ensure accuracy; then complete Section 5, sign and date Section 6.** If parent does not complete Section 5, center staff should complete to the best of their ability (by observation) and initial the section. The center will review completed enrollment form.

| 1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age) | 2 DAYS OF WEEK IN ATTENDANCE | 3 TIMES CHILD NORMALLY ATTENDS DURING WEEK | 4 MEALS RECEIVED |
|---|---|---|---|
| _____ *Child's First Name*<br>_____ *Child's Last Name*<br>_____ _____ *Date of Birth* *Age* | ☐ Monday<br>☐ Tuesday<br>☐ Wednesday<br>☐ Thursday<br>☐ Friday<br>☐ Saturday<br>☐ Sunday | see below | ☐ Breakfast<br>☐ AM Snack<br>☐ Lunch<br>☐ PM Snack<br>☐ Supper |

| TIME IN (check AM/PM and record time) | | | TIME OUT (check AM/PM and record time) | | | TIME CHILD ATTENDS SCHOOL (record in/out times) | |
|---|---|---|---|---|---|---|---|
| AM | PM | Time | AM | PM | Time | Leaves Center | Returns To Center |
| | | | | | | | |

☐ Yes ☐ No — I work multiple shifts and child(ren) may be in care different days/hours.

**5 Ethnic/Racial Categories**
***Please answer both questions. This information is voluntary.***

| | |
|---|---|
| A. Ethnic data of child(ren): **Mark one only** | ☐ Hispanic or Latino ☐ Not Hispanic or Latino |
| B. Racial data of child(ren): **Mark one or more that apply** | ☐ Asian ☐ White ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native |

**6 Signature and Date (parent or guardian must complete this section)**

*I certify the information above is correct.*

_____ *Signature of Parent or Guardian*  _____ *Date*  _____ *Parent's Telephone Number (optional)*

NON-DISCRIMINATION STATEMENT: The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer.

**Child Care Representative Use Only**

Effective Date of This Enrollment Form: _____

*The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.*

This form is effective for 12 months from the date of parent signature.

_____ *Signature of Center Representative*  _____ *Date*

# VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS and FAMILY DAY HOMES

## 1 All Household Members | 2 | 3

| | NAMES OF ALL HOUSEHOLD MEMBERS (Adults and Children)<br>First, Middle Initial, Last | Check if NO income | Ages of children at center | FOSTER CHILD<br>Skip to Part 6 if all are foster children. | SNAP, TANF or FDPIR CASE #<br>Skip to Part 6 if you list a SNAP, TANF or FDPIR case number.<br>MUST BE SEVEN (7) DIGITS |
|---|---|---|---|---|---|
| 1. | | ☐ | | ☐ | |
| 2. | | ☐ | | ☐ | |
| 3. | | ☐ | | ☐ | |
| 4. | | ☐ | | ☐ | |
| 5. | | ☐ | | ☐ | |
| 6. | | ☐ | | ☐ | |

## 4 Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison, Migrant Coordinator.

## 5 Total Household Gross Income (before deductions). You must tell us how much and how often.

GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: $100/month, $100/twice a month, $100/every other week, $100/week)

| NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME) | Earnings From Work | | Welfare, Child Support, Alimony | | Pensions, Retirement, Social Security | | Worker's Comp, Unemployment, SSI, etc. (All other income) | |
|---|---|---|---|---|---|---|---|---|
| | Amount | How often? | Amount | How often? | Amount | How often? | Amount | How often? |
| i. | $ | | $ | | $ | | $ | |
| ii. | $ | | $ | | $ | | $ | |
| iii. | $ | | $ | | $ | | $ | |
| iv. | $ | | $ | | $ | | $ | |
| v. | $ | | $ | | $ | | $ | |

## 6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her social security number or mark the *I do not have a social security number* box.

X X X – X X – ___ ___ ___ ___
Social Security Number

☐ I do not have a social security number.

*I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

_______________ *Date* _______________ *Printed Name of Adult Household Member* _______________ *Signature of Adult Household Member*

## 7 Contact Information (Optional)

_______________ *Work Telephone Number (Include Area Code)* _______________ *Home Telephone Number (Include Area Code)* _______________ *Home Address (Number, Street, City, State, Zip Code)*

## 8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)

May we share your information on this application with the *FAMIS*, the complete health insurance program for every child in Virginia? If yes, do not sign below.

☐ No, I do not want my information from this application shared with the FAMIS. Date: _______________ Sign here: _______________

PRIVACY ACT STATEMENT: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of your social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

NON-DISCRIMINATION STATEMENT: The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer.

## *CHILD CARE REPRESENTATIVE USE ONLY – ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BELOW*

**SECTION A** Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12 — Convert income only if different frequencies of pay are reported.

TOTAL INCOME $ _______________ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year NUMBER IN HOUSEHOLD: _______

| ☐ FREE based on: | ☐ REDUCED based on: | ☐ DENIED reason: |
|---|---|---|
| ☐ foster child ☐ migrant ☐ SNAP or TANF<br>☐ homeless ☐ runaway ☐ household income | ☐ household income | ☐ income too high ☐ incomplete application<br>☐ non-qualifying SNAP/TANF |

**SECTION B** Signature of Determining Official: _______________ Date: _______________